NPAIHB Roster of Pending Federal Healthcare Regulations, Legislation, and Submitted Comments
10/2/2017

Title/Agency Action/Regulation Link	Agency release date; due date for comments	Agency's Summary of Action	Notes:
PRIORITY REGULATIONS			
340B Drug Pricing Program Ceiling Price and Manufacturer Civil Monetary Penalties Regulation **AGENCY: HRSA** **Final rule; further delay of effective date**	Published: 9/29/2017 **Effective: 7/1/2018**	The Health Resources and Services Administration (HRSA) administers section 340B of the Public Health Service Act (PHSA), known as the ''340B Drug Pricing Program'' or the ''340B Program.'' HRSA published a final rule on January 5, 2017, that set forth the calculation of the ceiling price and application of civil monetary penalties. The final rule applied to all drug manufacturers that are required to make their drugs available to covered entities under the 340B Program. On August 21, 2017, HHS solicited comments on further delaying the effective date of the January 5, 2017, final rule to July 1, 2018 (82 FR 39553). HHS proposed this action to allow a more deliberate process of considering alternative and supplemental regulatory provisions and to allow for sufficient time for additional rulemaking. After consideration of the comments received on the proposed rule, HHS is delaying the effective date of the January 5, 2017, final rule, to July 1, 2018.	
HHS Draft Department Strategic Plan for FY 2018-2022 **AGENCY: HHS** https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-20613.pdf	Published: 9/27/2017 **Due Date: 10/26/2017**	The Department of Health and Human Services (HHS) is seeking public comment on its draft Strategic Plan for Fiscal Years 2018–2022. This document articulates how the Department will achieve its mission through five strategic goals. These five strategic goals are (1) Reform, Strengthen, and Modernize the Nation's Health Care System, (2) Protect the Health of Americans Where They Live, Learn, Work, and Play, (3) Strengthen the Economic and Social Well-Being of Americans across the Lifespan, (4) Foster Sound, Sustained Advances in Sciences, and (5) Promote Effective and Efficient Management and Stewardship. Each goal is supported by objectives and strategies. https://www.hhs.gov/ about/strategic-plan/index.html	 hhs-draft-strategic-plan-fy2018-2022.pc
Request for Public Comment: 60 Day Notice for Extension of Fast Track Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery: IHS Customer Service Satisfaction and Similar	Published: 9/27/2017 **Due Date: 11/27/2017**	Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery: IHS Customer Service Satisfaction and Similar Surveys. Type of Information Collection Request: Three year extension approval of this information collection.	

Surveys **AGENCY: IHS** **Request for Comments and Request for Extension of Approval** https://www.gpo.gov/fdsys/pkg/FR-2017-09-27/pdf/2017-20606.pdf		The proposed information collection activity provides a means to garner qualitative customer and stakeholder feedback in an efficient, timely manner, in accordance with the Administration's commitment to improving service delivery. Qualitative feedback is information that provides useful insights on perceptions and opinions, but is not statistical surveys that yield quantitative results that can be generalized to the population of study. This feedback will provide insights into customer or stakeholder perceptions, experiences and expectations, provide an early warning of issues with service, or focus attention on areas where communication, training or changes in operations might improve delivery of products or services. These collections will allow for ongoing, collaborative and actionable communications between the Agency and its customers and stakeholders. It will also allow feedback to contribute directly to the improvement of program management. The solicitation of feedback will target areas such as: Timeliness, appropriateness, accuracy of information, courtesy, efficiency of service delivery, and resolution of issues with service delivery. Responses will be assessed to plan and inform efforts to improve or maintain the quality of service offered to the public. If this information is not collected, vital feedback from customers and stakeholders on the agency's services will be unavailable.	
CMS Innovation Center New Direction Request for Information (RFI) **AGENCY: CMS** https://innovation.cms.gov/initiatives/direction/ https://innovation.cms.gov/Files/x/newdirection-rfi.pdf	Published: 9/20/2017 **Due Date: 11/20/2017**	One of the most important goals at CMS is fostering an affordable, accessible healthcare system that puts patients first. Through this informal Request for Information (RFI) the CMS Innovation Center (Innovation Center) is seeking your feedback on a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. The Innovation Center welcomes stakeholder input on the ideas included here, on additional ideas and concepts, and on the future direction of the Innovation Center. While existing partnerships with healthcare providers, clinicians, states, payers and stakeholders have generated important value and lessons, CMS is setting a new direction for the Innovation Center. We will carefully evaluate how models developed consistent with the new directions can complement what we are learning from the existing	Submit comments online: https://survey.max.gov/429625 Email comments: CMMI_NewDirection@cms.hhs.gov

		initiatives. In particular, the Innovation Center is interested in testing models in the following eight focus areas: 1. Increased participation in Advanced Alternative Payment Models (APMs); 2. Consumer-Directed Care & Market-Based Innovation Models; 3. Physician Specialty Models; 4. Prescription Drug Models; 5. Medicare Advantage (MA) Innovation Models; 6. State-Based and Local Innovation, including Medicaid-focused Models; 7. Mental and Behavioral Health Models; and 8. Program Integrity. However, the Innovation Center may also test models in other areas.	
Notice of Availability of Final Policy Document **AGENCY: HRSA** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-20/pdf/2017-19938.pdf	Published: 9/20/2017 **Effective: 8/28/2017**	The Health Center Program Compliance Manual (Compliance Manual) has been developed as a comprehensive, significantly streamlined, and web-based guidance document to assist health centers in understanding and demonstrating compliance with Health Center Program requirements. As such, this guidance document will reduce burden for current and prospective health centers and look-alikes and further strengthen HRSA's oversight of the Health Center and Health Center Federal Tort Claims Act (FTCA) Programs. It also responds to recommendations contained within the Government Accountability Office report, Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance with Requirements, GAO–12–546, for increased transparency, clarity, and consistency in Health Center Program oversight. The Bureau of Primary Health Care (BPHC) released a draft Compliance Manual on August 23, 2016, for a 90-day public comment period. Individuals and groups submitted over 700 comments regarding the draft Compliance Manual. After thorough review and consideration of all comments received, HRSA made a substantial number of updates to the Compliance Manual to incorporate suggestions and requests for further clarification. HRSA Health Center Program Compliance Manual	
Proposed Data Collection Submitted for	Published:	This notice invites comment on a proposed information collection	

Public Comment and Recommendations; Effective Communication in Public Health Emergencies- Developing Community-Centered Tools for People with Special Health Care Needs **Docket No. CDC-2017-0071** **AGENCY: CDC** **Notice with comment period** https://www.gpo.gov/fdsys/pkg/FR-2017-09-20/pdf/2017-19959.pdf	9/20/2017 **Due Date: 11/20/2017**	project titled "Effective Communication in Public Health Emergencies—Developing Community-Centered Tools for People with Special Health Care Needs" Office of Public Health Preparedness and Response (OPHPR), Centers for Disease Control and Prevention (CDC). The data resulting from this study will be used to develop specific tools, protocols, and message templates that can be used for communicating during emergencies and disasters with families with CYSHCN and ASD. CDC plans to begin the information collection one month after OMB approval and continue for twenty two months.	
Solicitation of Nominations for Appointment to the Healthcare Infection Control Practices Advisory Committee (HICPAC) **AGENCY: CDC** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-18/pdf/2017-19743.pdf	Published: 9/18/2017 **Due Date: 11/30/2017**	The Centers for Disease Control and Prevention (CDC) is seeking nominations for membership on the HICPAC. The HICPAC consists of 14 experts in fields including but not limited to, infectious diseases, infection prevention, healthcare epidemiology, nursing, clinical microbiology, surgery, hospitalist medicine, internal medicine, epidemiology, health policy, health services research, public health, and related medical fields. Nominations are being sought for individuals who have expertise and qualifications necessary to contribute to the accomplishments of the committee's objectives. Nominees will be selected based on expertise in the fields of infectious diseases, infection prevention, healthcare epidemiology, nursing, environmental and clinical microbiology, surgery, internal medicine, epidemiology, health policy, health services research, and public health. Federal employees will not be considered for membership. Members may be invited to serve for four-year terms.	
Agency Information Collection: State Medicaid HIT Plan and Limitations on Provider Related Donations and Health Care Related Taxes. **AGENCY: CMS** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-18/pdf/2017-19787.pdf	Published: 9/18/2017 **Due Date: 10/18/2017**	1. Extension of a currently approved collection; Title of Information Collection: State Medicaid HIT Plan, Planning Advance Planning Document, and Implementation Advance Planning Document for Section 4201 of the Recovery Act; Use: To assess the appropriateness of state requests for the administrative Federal financial participation for expenditures under their Medicaid Electronic Health Record Incentive Program related to health information exchange, our staff will review the submitted information and documentation to make an approval determination of the state advance planning document. Form Number: CMS–	

		10292 2. Extension of a currently approved collection; Title of Information Collection: Limitations on Provider Related Donations and Health Care Related Taxes; Limitation on Payment to Disproportionate Share Hospitals; Medicaid and Supporting Regulations; Use: States may request a waiver of the broad based and uniformity tax program requirements. Each state must demonstrate that its tax program(s) do not violate the hold harmless provision. Additionally, state Medicaid agencies must report (quarterly) on health care related taxes collected and the source of provider related donations received by the state or unit of local government. Each state must maintain, in readily reviewable form, supporting documentation that provides a detailed description of each donation and tax program being reported, as well as the source and use of all donations received and collected. Without this information, the amount of Federal financial participation payable to a state cannot be determined; Form Number: CMS–R–148.	
Agency Information Collection: CMS-437 Psychiatric Unit Criteria Work Sheet and CMS-10515 Payment Collections Operations Contingency Plan **AGENCY: CMS** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-18/pdf/2017-19795.pdf	Published: 9/18/2017 **Due Date: 11/17/2017**	1. Reinstatement with Change of a currently approved collection; Title of Information Collection: Psychiatric Unit Criteria Work Sheet; Use: Certain specialty hospitals and hospital specialty distinct-part units may be excluded from the Inpatient Medicare Prospective Payment System (IPPS) and be paid at a different rate. These specialty hospitals and distinct-part units of hospitals include Inpatient Rehabilitation Facilities (IRFs) units, Inpatient Rehabilitation Facilities (IRFs) hospitals and Inpatient Psychiatric Facilities (IPFs). 2. Extension of a currently approved collection; Title of Information Collection: Payment Collections Operations Contingency Plan; Use: Section 1402 of the PPACA provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange, and section 1412 of the PPACA provides for the advance payment of these reductions to issuers. The data collection will be used by HHS to make payments or collect charges from SBE issuers under the following programs: advance payments of the premium tax credit, advanced cost-sharing reductions, and Exchange user fees. The workbook template was used to make payments in January 2014 and will continue through December 2020, as may be	

		required based on HHS's operational progress. Form Number: CMS–10515	
Social Security Ruling, SSR 17-3pl Titles II and XVI: Evaluating Cases Involving Sickle Cell Disease (SCD) **AGENCY: Social Security Administration** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-15/pdf/2017-19551.pdf	Published: 9/15/2017 **Effective: 9/15/2017**	We consider all medical evidence when we evaluate a claim for disability benefits. The following information is in a question and answer format that provides guidance about SCD and how to consider evidence regarding this impairment. Questions 1 and 2 provide basic background information about SCD and its variants. Question 3 clarifies that sickle cell trait is not a variant of SCD. Question 4 discusses the complications and symptoms of SCD.	
Agency Information Collection; Medicare Geographic Classification Review Board Procedures and Disclosure Requirement for the IN-Office Ancillary Services Exception **AGENCY: CMS** **Notice** https://www.gpo.gov/fdsys/pkg/FR-2017-09-15/pdf/2017-19521.pdf	Published: 9/15/2017 **Due Date: 10/16/2017**	1. Extension of a currently approved collection; Title of Information Collection: Medicare Geographic Classification Review Board Procedures and Criteria; Use: During the first few years of IPPS, hospitals were paid strictly based on their physical geographic location concerning the wage index (Metropolitan Statistical Areas (MSAs)) and the standardized amount (rural, other urban, or large urban). However, a growing number of hospitals became concerned that their payment rates were not providing accurate compensation. The hospitals argued that they were not competing with the hospitals in their own geographic area, but instead that they were competing with hospitals in neighboring geographic areas. At that point, Congress enacted Section 1886(d)(10) of the Act which enabled hospitals to apply to be considered part of neighboring geographic areas for payment purposes based on certain criteria. The application and decision process is administered by the MGCRB which is not a part of CMS so that CMS could not be accused of any untoward action. However, CMS needs to remain apprised of any potential payment changes. 2. Extension of a currently approved collection; Title of Information Collection: Disclosure Requirement for the In-Office Ancillary Services Exception; Use: Section 6003 of the ACA established a disclosure requirement for the in-office ancillary services exception to the prohibition of physician self-referral for certain imaging services. This section of the ACA amended section 1877(b)(2) of the Social Security Act by adding a requirement that the referring	

		physician informs the patient, at the time of the referral and in writing, that the patient may receive the imaging service from another supplier.	
Agency Information Collection; Project: Biannual Infrastructure Development Measures for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination Implementation (SYT–I) and Adolescent and Transitional Aged Youth Treatment Implementation **AGENCY: SAMHSA** https://www.gpo.gov/fdsys/pkg/FR-2017-09-12/pdf/2017-19251.pdf	Published: 9/12/2017 **Due Date: 10/12/2017**	The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment has developed a set of infrastructure development measures in which recipients of cooperative agreements will report on various benchmarks on a semi-annual basis. The infrastructure development measures are designed to collect information at the state-level and site-level. The projects were previously named State Adolescent Treatment Enhancement and Dissemination (SAT– ED) and State Youth Treatment Enhancement and Dissemination (SYT– ED) Programs and are now called State Adolescent And Transitional Aged Youth Treatment Enhancement and Dissemination Implementation (SYT–I) and Adolescent and Transitional Aged Youth Treatment Implementation (YT–I) Programs. No changes have been made to the Biannual Infrastructure Development Measures Report. The only revision to the biannual progress report is due to the decrease in the number of respondents. The infrastructure development measures are based on the programmatic requirements. The purpose of this program is to provide funding to States/Territories/ Tribes to improve treatment for adolescents and transitional age youth through the development of a learning laboratory with collaborating local community-based treatment provider sites.	
Medicare Program; Recognition of Revised NAIC Model Standards for Regulation of Medicare Supplemental Insurance **AGENCY: CMS** https://www.gpo.gov/fdsys/pkg/FR-2017-09-01/pdf/2017-18605.pdf	Published: 9/1/2017 **Effective: 1/1/2020**	This notice announces the changes made by the Medicare Access and CHIP Reauthorization of 2015 (MACRA) to section 1882 of the Social Security Act (the Act), which governs Medicare supplemental insurance. This notice also recognizes that the Model Regulation adopted by the National Association of Insurance Commissioners (NAIC) on August 29, 2016, is considered to be the applicable NAIC Model Regulation for purposes of section 1882 of the Act, subject to our clarifications that are set forth in this notice.	
Cost-Based and Inter-Agency Billing Rates for Medical Care or Services Provided by the VA	Published: 8/29/2017	Updates the Cost-Based and Inter-Agency billing rates for medical care or services provided by the Department of Veterans Affairs (VA) that	

AGENCY: VA https://www.gpo.gov/fdsys/pkg/FR-2017-08-29/pdf/2017-18219.pdf	**Effective: 8/29/2017**	apply in certain circumstances. Inter-Agency rates apply to medical care and services that are provided by VA to beneficiaries of the Department of Defense (DoD) or other Federal agencies, when the care or services provided is not covered by an applicable sharing agreement, unless otherwise stated. The calculations for the Cost-Based and Inter-Agency rates are the same with two exceptions. Inter-Agency rates are all-inclusive, and are not broken down into three components (Physician; Ancillary; and Nursing, Room and Board), and Inter-Agency rates do not include standard fringe benefit costs that cover government employee retirement, disability costs, and return on fixed assets. When VA pays for medical care or services from a non-VA source under circumstances in which the Cost-Based or Inter-Agency Rates would apply if the care or services had been provided by VA, the charge for such care or services will be the actual amount paid by VA for the care or services. Inpatient charges will be at the per diem rates shown for the type of bed section or discrete treatment unit providing the care.	
Agency Information Collection; To Advance State, Tribal, Local and Territorial Governmental Agency and System Performance, Capacity, and Program Delivery. CDC is requesting a 3 year approval **AGENCY: CDC** https://www.gpo.gov/fdsys/pkg/FR-2017-08-25/pdf/2017-18035.pdf	Published: 8/25/2017	Information Collections to Advance State, Tribal, Local and Territorial (STLT) Governmental Agency and System Performance, Capacity, and Program Delivery. CDC is requesting a three-year approval for a generic clearance to collect information related to domestic public health issues and services that affect and/or involve state, tribal, local and territorial (STLT) government entities. CDC and HHS seek to accomplish its mission by collaborating with partners throughout the nation and the world to: Monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training	
Eligibility for Supplemental Service-Disabled Veterans' Insurance **AGENCY: VA** **Proposed Rule** https://www.gpo.gov/fdsys/pkg/FR-	Published: 8/23/2017 **Due Date: 10/23/2017**	The Department of Veterans Affairs (VA) proposes to amend its regulations governing the Service Disabled Veterans' Insurance (S–DVI) program in order to explain that a person who was granted S–DVI as of the date of death under is not eligible for supplemental S–DVI because the insured's total disability did not begin after the date of the insured's application for insurance and while the insurance was in force under	

2017-08-23/pdf/2017-17587.pdf		premium paying conditions. Under 38 U.S.C. 1922(a), a veteran ''suffering from a disability or disabilities for which compensation would be payable if 10 per centum or more in degree and except for which such person would be insurable according to the standards of good health'' is eligible for S–DVI up to a maximum of $10,000 upon ''application in writing made within two years from the date service connection of such disability is determined by the Secretary and payment of premiums as provided in this subchapter.'' A grant of supplemental S–DVI is precluded if S– DVI was granted under section 1922(b). This would reflect the Veterans Court's conclusion that the insured cannot qualify for a waiver of premiums under 38 U.S.C. 1912(a) because the insured's total disability did not begin after the date of the insured's application for insurance and while the insurance was in force under premium-paying conditions.	
Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices **AGENCY: CMS** **Final Rule** https://www.gpo.gov/fdsys/pkg/FR-	Published: 8/14/2017 **Effective: 10/1/2017**	CMS is revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2018. Some of these changes implement certain statutory provisions contained in the Pathway for Sustainable Growth Rate (SGR) Reform Act of 2013, the Improving Medicare Post-Acute Care Transformation Act of 2014, the Medicare Access and CHIP Reauthorization Act of 2015, the 21st Century Cures Act, and other legislation. CMS is also are making changes relating to the provider-based status of Indian Health Service (IHS) and Tribal facilities and organizations and to the low-volume hospital payment adjustment for hospitals operated by the IHS or a Tribe. In addition, we are providing the market basket update that will apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits for FY 2018. CMS is updating the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2018.	 Final Medicare IPPS_FY 2018_Grand It doesn't appear that any of our comments were accepted. But for several comments CMS has stated that they will consider for future rulemaking.

2017-08-14/pdf/2017-16434.pdf			
		DEAR TRIBAL LEADER LETTERS	
IHS Tribal Consultation and Urban Confer on the IHS Strategic Plan https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2017_Letters/58653-1_IHS_StrategicPlan_09152017.pdf	Published: 9/15/2017 **Due Date: 10/31/2017**	IHS is initiating a Tribal Consultation and Urban Confer on the IHS Strategic Plan. IHS is beginning a process for the development of a 5-year IHS Strategic Plan 2018-2022. This coincides with the development of the HHS Strategic Plan for 2018-2022. IHS Strategic Plan Consultation Timeline and Draft Framework for IHS Mission, Goals, and Objectives	Listening Session scheduled for Wednesday, October 18 3:00-4:00PM ET
IHS is Accepting Applications for the Small Ambulatory Program https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2017_Letters/58580-1_DTLL_SAP_OEHE_08252017.pdf	Published: 8/25/2017 **Due Date: 12/1/2017**	The fiscal year (FY) 2017 budget includes $5 million for the Small Ambulatory Program (SAP). The Indian Health Service (IHS) is accepting applications for the SAP. The authorization for the SAP is in Title 25 U.S.C. Section 1636. Under the SAP, American Indian and Alaska Native Tribes or Tribal organizations who are operating an Indian health care facility pursuant to a health care services contract or compact entered into under the Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638, may competitively obtain funding for the construction, expansion, or modernization of small ambulatory health care facilities. If your Tribe is interested in participating in the FY 2017 SAP, please download and complete the application available online at https://www.ihs.gov/dfpc/ or http://www.fedbizopps.gov by December 1, 2017.	
		FUNDING OPPORTUNITIES	
Native Elder Abuse Innovation Awards 2018 **National Indigenous Elder Justice Initiative**	**Published: 9/15/2017** **Due Date: 11/14/2017**	These grants are intended to provide American Indian Tribes, Alaskan Natives, and Native Hawaiians with funds to focus on awareness, policy development, and infrastructure building for reporting, investigation, and intervention of elder abuse and neglect for Indigenous elders or other innovative elder abuse projects. NIEJI Innovation plans to award	

https://www.nieji.org/innovation-grant/awards	**Award Notification: 1/2/2018**	between 8-12 awards, up to $20,000 to each grantee.	
Zero Suicide Initiative Support **IHS Division of Behavioral Health; Office of Clinical and Preventative Services** https://www.gpo.gov/fdsys/pkg/FR-2017-08-21/pdf/2017-17599.pdf	**Published: 8/21/2017** **Due Date: 10/12/2017** **Start Date: 11/1/2017**	The Indian Health Service (IHS), Office of Clinical and Preventive Service, Division of Behavioral Health (DBH), is accepting applications for cooperative agreements for Zero Suicide Initiative (ZSI)—to develop a comprehensive model of culturally informed suicide care within a system of care framework. This program was first established by the Consolidated Appropriations Act of 2017, Public Law 115–31, 131 Stat. 135 (2017). The purpose of this cooperative agreement is to improve the system of care for those at risk for suicide by implementing a comprehensive, culturally informed, multi-setting approach to suicide prevention in Indian health systems. This award represents a continuation of IHS's efforts to implement the Zero Suicide approach in Indian Country. Existing efforts have focused on training, technical assistance, and consultation for several 'pilot' AI/AN Zero Suicide communities. As a result of these efforts, both the unique opportunities and challenges of implementing Zero Suicide in Indian Country have been identified. The total amount of funding identified for the current fiscal year (FY) 2018 is approximately $2,000,000. Individual award amounts are anticipated to be approximately $400,000. The amount of funding available for non-competing and continuation awards issued under this announcement is subject to the availability of appropriations and budgetary priorities of the Agency. IHS is under no obligation to make awards that are selected for funding under this announcement. Approximately five (5) awards will be issued under this program announcement. Project Period The project period is for three years and will run consecutively from November 1, 2017, to October 31, 2020.	

NPAIHB Roster of Pending Federal Healthcare Regulations, Legislation, and Submitted Comments
9/28/2017

		115th CONGRESS LEGISLATION	
H.R. 3823 Disaster Tax Relief and Airport and Airway Extension Act Sec. 301 Extension of Certain Public Health Programs - SDPI **House Ways and Means Committee** **House Transportation and Infrastructure Committee** **House Energy and Commerce Committee** **House Committee on Financial Services** **House Budget Committee** **Sponsor: Rep. Kevin Brady (R-TX-8)** https://www.congress.gov/bill/115th-congress/house-bill/3823/text?q=%7B%22search%22%3A%5B%22HR+3823%22%5D%7D&r=1	Introduced: 9/25/2017	To amend title 49, United States Code, to extend authorizations for the airport improvement program, to amend the Internal Revenue Code of 1986 to extend the funding and expenditure authority of the Airport and Airway Trust Fund, to provide disaster tax relief, and for other purposes. EXTENSION OF SPECIAL DIABETES PROGRAM FOR INDIANS.—Section 330C(c)(2) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)) is amended—	2 cosponsors Not agreed to in House Roll Call: 245-171
S. 1827 KIDS Act of 2017 **Senate Finance Committee** **Sponsor: Sen. Orrin Hatch (R-UT)** https://www.congress.gov/bill/115th-congress/senate-bill/1827/text?q=%7B%22search%22%3A%5B%22S+1827%22%5D%7D&r=1	Introduced 9/18/2017	To extend funding for the Children's Health Insurance Program, and for other purposes. SEC.2. FIVE_YEAR FUNDING EXTENSION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM (21) for fiscal year 2018, $21,500,000,000; "(22) for fiscal year 2019, $22,600,000,000; "(23) for fiscal year 2020, $23,700,000,000; "(24) for fiscal year 2021, $24,800,000,000; and "(25) for fiscal year 2022, for purposes of making 2 semi-annual allotments— "(A) $2,850,000,000 for the period beginning on October 1, 2021, and ending on March 31, 2022; and "(B) $2,850,000,000 for the period beginning on April 1, 2022, and ending on September 30, 2022.".	

S.1804 Medicare For All **Senate Finance Committee** **Sponsor: Sen. Bernie Sanders (I-VT)** https://www.congress.gov/bill/115th-congress/senate-bill/1804/text?q=%7B%22search%22%3A%5B%22medicare+for+all%22%5D%7D&r=1	Introduced: 9/13/2017	To establish a Medicare-for-all national health insurance program. TITLE I—ESTABLISHMENT OF THE UNIVERSAL MEDICARE PROGRAM; UNIVERSAL ENTITLEMENT; ENROLLMENT Sec. 101. Establishment of the Universal Medicare Program. Sec. 102. Universal entitlement. Sec. 103. Freedom of choice. Sec. 104. Non-discrimination. Sec. 105. Enrollment. Sec. 106. Effective date of benefits. Sec. 107. Prohibition against duplicating coverage. TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG-TERM CARE Sec. 201. Comprehensive benefits. Sec. 202. No cost-sharing. Sec. 203. Exclusions and limitations. Sec. 204. Coverage of long-term care services under Medicaid. Sec. 205. State standards. TITLE III—PROVIDER PARTICIPATION Sec. 301. Provider participation and standards. Sec. 302. Qualifications for providers. Sec. 303. Use of private contracts. TITLE IV—ADMINISTRATION Subtitle A—General Administration Provisions Sec. 401. Administration. Sec. 402. Consultation. Sec. 403. Regional administration. Sec. 404. Beneficiary ombudsman. Sec. 405. Complementary conduct of related health	

		programs. Subtitle B—Control Over Fraud And Abuse Sec. 411. Application of Federal sanctions to all fraud and abuse under Universal Medicare Program. TITLE V—QUALITY ASSESSMENT Sec. 501. Quality standards. Sec. 502. Addressing health care disparities. TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES Subtitle A—Budgeting Sec. 601. National health budget. Subtitle B—Payments To Providers Sec. 611. Payments to institutional and individual providers. Sec. 612. Ensuring accurate valuation of services under the Medicare physician fee schedule. Sec. 613. Office of primary health care. Sec. 614. Payments for prescription drugs and approved devices and equipment. TITLE VII—UNIVERSAL MEDICARE TRUST FUND Sec. 701. Universal Medicare Trust Fund. TITLE VIII—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 Sec. 801. Prohibition of employee benefits duplicative of benefits under the Universal Medicare Program; coordination in case of workers' compensation. Sec. 802. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans. Sec. 803. Effective date of title. TITLE IX—ADDITIONAL CONFORMING AMENDMENTS	

		Sec. 901. Relationship to existing Federal health programs. Sec. 902. Sunset of provisions related to the State Exchanges. TITLE X—TRANSITION Subtitle A—Transitional Medicare Buy-In Option And Transitional Public Option Sec. 1001. Lowering the Medicare age. Sec. 1002. Establishment of the Medicare transition plan. Subtitle B—Transitional Medicare ReForMs Sec. 1011. Medicare protection against high out-of-pocket expenditures for fee-for-service benefits and elimination of parts A and B deductibles. Sec. 1012. Reduction in Medicare part D annual out-of-pocket threshold and elimination of cost-sharing above that threshold. Sec. 1013. Coverage of dental and vision services and hearing aids and examinations under Medicare part B. Sec. 1014. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities. TITLE XI—MISCELLANEOUS	
H.R. 3706 Native Health and Wellness Act of 2017 **House Energy and Commerce Committee** **Sponsor: Rep. Raul Ruiz (D-CA-36)** https://www.congress.gov/bill/115th-congress/house-bill/3706/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=38	Introduced: 9/7/2017	To amend the Public Health Service Act to improve the public health system in tribal communities and increase the number of American Indians and Alaska Natives pursuing health careers, and for other purposes. **"SEC. 317U. TRIBAL HEALTH BLOCK GRANT.** "(a) In General.—To the extent and in the amounts made available in advance by appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award a grant, in an amount determined pursuant to the formula developed under subsection (e), to each eligible Indian tribe or tribal organization for the purposes of promoting health,	1 cosponsor

		preventing disease, and reducing health disparities among American Indians and Alaska Natives. "(b) Consultation.—The Secretary shall carry out this section, including the development of the formula required by subsection (e), in consultation with eligible Indian tribes and tribal organizations. "(c) Eligibility.—To be eligible for a grant under this section for a fiscal year, an Indian tribe or tribal organization shall submit to the Secretary a plan at such time, in such manner, and containing such information as the Secretary may require. "(d) Use Of Funds.—Each grantee under this section shall use the grant funds— "(1) to establish or support preventive health service programs that facilitate the achievement of health-status goals; "(2) to establish or support public health services that reduce the prevalence of chronic disease among American Indians and Alaska Natives; or "(3) to strengthen public health infrastructure to facilitate the surveillance and response to infectious disease and foodborne illness outbreaks. "(e) Formula.—The Secretary shall develop a formula to be used in allocating the total amount of funds made available to carry out this section for a fiscal year among the eligible Indian tribes and tribal organizations. "(f) Reports.—Each grantee under this section shall submit reports at such time, in such manner, and containing such information as the Secretary may require. **"SEC. 779. RECRUITMENT AND MENTORING OF AMERICAN INDIAN AND ALASKA NATIVE YOUTH AND YOUNG ADULTS.** "(a) In General.—The Secretary shall make grants to Indian tribes and tribal organizations for the purpose of recruiting and mentoring American Indian and Alaska Native youth and young adults in health professions.	

		"(b) Use Of Funds.—An Indian tribe or tribal organization receiving a grant under subsection (a) shall use the grant funds— "(1) to expose American Indian and Alaska Native adolescent youth or young adults to health professions; "(2) to promote science education; "(3) to establish mentoring relationships between— "(A) American Indian and Alaska Native youth or young adults; and "(B) health professionals; "(4) to provide hands-on learning experiences in a health care setting; "(5) to establish partnerships with institutions of higher education (including tribal colleges), local educational agencies, and other community-based entities to develop a larger and more competitive applicant pool for health professional careers; or "(6) to provide counseling, mentoring, and other services designed to assist American Indian and Alaska Native youth or young adults in the pursuit of higher education with respect to health professions.	
H.R. 3704 Native Health Access Improvement Act of 2017 **House Energy and Commerce Committee** **House Natural Resources Committee** **House Ways and Means Committee** **Sponsor: Rep. Frank Pallone, Jr. (D-NJ-6)** https://www.congress.gov/bill/115th-congress/house-bill/3704/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=33	Introduced: 9/7/2017	To amend the Public Health Service Act to improve behavioral health outcomes for American Indians and Alaskan Natives, and for other purposes. **SEC. 506B. SPECIAL BEHAVIORAL HEALTH PROGRAM FOR INDIANS.** "(a) In General.—The Director of the Indian Health Service, in coordination with the Assistant Secretary for Mental Health and Substance Use, shall award grants for providing services in accordance with subsection (b) for the prevention and treatment of mental health and substance use disorders. "(b) Services Through Indian Health Facilities.—For purposes of subsection (a), services are provided in accordance with this subsection if the services are provided	1 cosponsor

		through any of the following entities: "(1) The Indian Health Service. "(2) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5301 et seq.). "(3) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.). "(c) Reports.—Each grantee under this section shall submit reports at such time, in such manner, and containing such information as the Director of the Indian Health Service may require. "(d) Technical Assistance Center.— "(1) ESTABLISHMENT.—The Director of the Indian Health Service, in coordination with the Assistant Secretary for Mental Health and Substance Use, shall establish a technical assistance center (directly or by contract or cooperative agreement)— "(A) to provide technical assistance to grantees under this section; and "(B) to collect and evaluate information on the program carried out under this section. "(2) CONSULTATION.—The technical assistance center shall consult with grantees under this section for purposes of developing evaluation measures and data submission requirements for purposes of the collection and evaluation of information under paragraph (1)(B). "(3) DATA SUBMISSION.—As a condition on receipt of a grant under this section, an applicant shall agree to submit data consistent with the data submission requirements developed under paragraph (2). "(e) Funding.— "(1) IN GENERAL.—For the purpose of making grants under	

		this section, there is authorized to be appropriated, and there is appropriated, out of any money in the Treasury not otherwise appropriated, $150,000,000 for each of fiscal years 2018 through 2022. "(2) TECHNICAL ASSISTANCE CENTER.—Of the amount made available to carry out this section for each of fiscal years 2018 through 2022, the Director of the Indian Health Service shall allocate a percentage of such amount, to be determined by the Director in consultation with Indian tribes, for the technical assistance center under subsection (d).	
H.R. 3473 **Native American Suicide Prevention Act of 2017** **House Energy and Commerce Committee** **Sponsor: Rep. Raul M. Grijalva (D-AZ-3)** https://www.congress.gov/bill/115th-congress/house-bill/3473/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=1	Introduced: 7/27/2017	To amend section 520E of the Public Health Service Act to require States and their designees receiving grants for development and implementation of statewide suicide early intervention and prevention strategies to collaborate with each Federally recognized Indian tribe, tribal organization, and urban Indian organization in the State.	
H.R. 3495 Opioid and Heroin Abuse Crisis Investment Act of 2017 **House Energy and Commerce Committee** **Sponsor: Rep. Ben Ray Lujan (D-NM-3)** https://www.congress.gov/bill/115th-congress/house-bill/3495/text?q=%7B%22search%22%3A%5B%22opioid%22%5D%7D&r=2	Introduced: 7/27/2017	To amend the 21st Century Cures Act to appropriate funds for the Account for the State Response to the Opioid Abuse Crisis through fiscal year 2023, and for other purposes. "(C) APPROPRIATIONS AFTER FISCAL YEAR 2018.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the Account For the State Response to the Opioid Abuse Crisis $500,000,000 for each of fiscal years 2019 through 2023."; 	15 cosponsors

H.R. 3254 Heroin and Opioid Abuse Prevention and Treatment Act of 2017 **House Ways and Means Committee** **House Energy and Commerce Committee** **House Budget Committee** **Sponsor: Rep. Michelle Lujan Grisham (D-NM-1)** https://www.congress.gov/bill/115th-congress/house-bill/3254/text?q=%7B%22search%22%3A%5B%22opioid%22%5D%7D&r=3	Introduced: 7/14/2017	To amend the Internal Revenue Code to impose an excise tax on opioid manufacturers, to make the funds collected through such tax available for opioid (including heroin) abuse prevention and treatment programs, and for other purposes. **SEC. 3. GRANTS TO STATES FOR PREVENTION AND TREATMENT OF OPIOID (INCLUDING HEROIN) ABUSE.** (a) In General.—The Public Health Service Act is amended by inserting after section 399V–6 (42 U.S.C. 280g–17) the following new section: (b) **"SEC. 399V–7. PREVENTION AND TREATMENT OF OPIOID (INCLUDING HEROIN) ABUSE.** "(a) In General.—The Secretary shall provide— "(1) grants to States for research on opioids (including heroin); and "(2) grants to States for opioid abuse prevention and treatment, which may include— "(A) establishing new addiction treatment facilities for opioid addicts; "(B) establishing sober living facilities for recovering opioid addicts; "(C) recruiting and increasing reimbursement for certified mental health providers providing opioid abuse treatment in medically underserved communities or communities with high rates of opioid abuse; "(D) expanding access to long-term, residential treatment programs for opioid addicts and recovering addicts; "(E) establishing or operating support programs that offer employment services, housing, and other support services for recovering opioid addicts; "(F) establishing or operating housing for children whose parents are participating in opioid abuse treatment programs; "(G) establishing or operating facilities to provide care for babies born with neonatal abstinence syndrome;	4 cosponsors

		"(H) establishing or operating controlled opioid take-back programs; and "(I) other opioid abuse prevention and treatment programs, as the Secretary determines appropriate.	
H.R. 2662 Restoring Accountability in the Indian Health Service Act of 2017 **House Natural Resources Committee** **House Energy and Commerce Committee** **House Ways and Means Committee** **House Oversight and Government Reform Committee** **Sponsor: Rep. Kristi Noem (R-SD-At Large)** https://www.congress.gov/bill/115th-congress/house-bill/2662/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=24	Introduced: 5/25/2017	To amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes. Sec. 1. Short title. Sec. 2. Table of contents. TITLE I—INDIAN HEALTH SERVICE IMPROVEMENTS Sec. 101. Incentives for recruitment and retention. Sec. 102. Medical credentialing system. Sec. 103. Liability protections for health professional volunteers at Indian Health Service. Sec. 104. Clarification regarding eligibility for Indian Health Service loan repayment program. Sec. 105. Improvements in hiring practices. Sec. 106. Removal or demotion of Indian Health Service employees based on performance or misconduct. Sec. 107. Standards to improve timeliness of care. Sec. 108. Tribal culture and history. Sec. 109. Staffing demonstration project. Sec. 110. Rule establishing tribal consultation policy. TITLE II—EMPLOYEE PROTECTIONS Sec. 201. Right of Federal employees to petition Congress. Sec. 202. Fiscal accountability. TITLE III—REPORTS Sec. 301. Definitions. Sec. 302. Reports by the Secretary of Health and Human Services.	8 cosponsors Related bill: S.1250 Restoring Accountability in the Indian Health Service Act of 2017 6/21/2017 Hearing held in the House Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs

		Sec. 303. Reports by the Comptroller General. Sec. 304. Inspector General reports. Sec. 305. Transparency in CMS surveys.	
S. 1250 Restoring Accountability in the Indian Health Service Act of 2017 **Senate Committee on Indian Affairs** **Sponsor: Sen. John Barrasso (R-WY)** https://www.congress.gov/bill/115th-congress/senate-bill/1250/text?q=%7B%22search%22%3A%5B%22S+1250%22%5D%7D&r=1	Introduced: 5/25/2017	To amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes. TITLE I—INDIAN HEALTH SERVICE IMPROVEMENTS Sec. 101. Incentives for recruitment and retention. Sec. 102. Medical credentialing system. Sec. 103. Liability protections for health professional volunteers at Indian Health Service. Sec. 104. Clarification regarding eligibility for Indian Health Service loan repayment program. Sec. 105. Improvements in hiring practices. Sec. 106. Removal or demotion of Indian Health Service employees based on performance or misconduct. Sec. 107. Standards to improve timeliness of care. Sec. 108. Tribal culture and history. Sec. 109. Staffing demonstration project. Sec. 110. Rule establishing tribal consultation policy. TITLE II—EMPLOYEE PROTECTIONS Sec. 201. Right of Federal employees to petition Congress. Sec. 202. Fiscal accountability. TITLE III—REPORTS Sec. 301. Definitions. Sec. 302. Reports by the Secretary of Health and Human Services. Sec. 303. Reports by the Comptroller General. Sec. 304. Inspector General reports. Sec. 305. Transparency in CMS surveys. TITLE IV—TECHNICAL AMENDMENTS	2 cosponsors Related bill: H.R. 2662 Restoring Accountability in the Indian Health Service Act of 2017 6/13/2017 Hearing held by the Senate Committee on Indian Affairs
H.R. 2545 **Special Diabetes Program for Indians Reauthorization Act of 2017**	Introduced: 5/18/2017	Referred to the Subcommittee on Health 5/19/2017 This Act may be cited as the “Special Diabetes Program for Indians Reauthorization Act of 2017 ”.	17 cosponsors

House Energy and Commerce Committee **Sponsor: Rep. Norma J. Torres (D-CA-35)** https://www.congress.gov/bill/115th-congress/house-bill/2545/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=7		Section 330C(c) of the Public Health Service Act (42 U.S.C. 254c–3(c)) is amended by striking paragraph (2) and inserting the following: "(2) APPROPRIATIONS.— "(A) IN GENERAL.—For the purpose of making grants under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated— "(i) $150,000,000 for fiscal year 2018; and "(ii) the amount specified in subparagraph (B) for each of fiscal years 2019 through 2024.	
S. 747 Special Diabetes Program for Indians Reauthorization Act of 2017 **Senate Health, Education, Labor and Pensions Committee** **Sponsor: Sen. Tom Udall (D-NM)** https://www.congress.gov/bill/115th-congress/senate-bill/747/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=8	Introduced: 3/28/2017	This Act may be cited as the "Special Diabetes Program for Indians Reauthorization Act of 2017". Section 330C(c) of the Public Health Service Act (42 U.S.C. 254c–3(c)) is amended by striking paragraph (2) and inserting the following: "(2) APPROPRIATIONS.— "(A) IN GENERAL.—For the purpose of making grants under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated— "(i) $150,000,000 for fiscal year 2018; and "(ii) the amount specified in subparagraph	Related Bills: H.R. 2545 Special Diabetes Program for Indians Reauthorization Act of 2017

		(B) for each of fiscal years 2019 through 2024.	
H.R. 1369 Indian Healthcare Improvement Act of 2017 **House Natural Resources Committee** **House Energy and Commerce Committee** **House Ways and Means Committee** **House Budget Committee** **Sponsor: Rep. Tom Cole (R-OK-4)**	Introduced: 3/6/2017	Sec. 101. Reauthorization. Sec. 102. Findings. Sec. 103. Declaration of national Indian health policy. Sec. 104. Definitions. Subtitle A—Indian Health Manpower Sec. 111. Community Health Aide Program. Sec. 112. Health professional chronic shortage demonstration programs. Sec. 113. Exemption from payment of certain fees. Subtitle B—Health Services Sec. 121. Indian Health Care Improvement Fund. Sec. 122. Catastrophic Health Emergency Fund. Sec. 123. Diabetes prevention, treatment, and control. Sec. 124. Other authority for provision of services; shared services for long-term care. Sec. 125. Reimbursement from certain third parties of costs of health services. Sec. 126. Crediting of reimbursements. Sec. 127. Behavioral health training and community education programs. Sec. 128. Cancer screenings. Sec. 129. Patient travel costs. Sec. 130. Epidemiology centers. Sec. 131. Indian youth grant program. Sec. 132. American Indians Into Psychology Program. Sec. 133. Prevention, control, and elimination of communicable and infectious diseases. Sec. 134. Methods to increase clinician recruitment and retention issues. Sec. 135. Liability for payment. Sec. 136. Offices of Indian Men's Health and Indian Women's Health. Sec. 137. Contract health service administration and disbursement formula. Subtitle C—Health Facilities Sec. 141. Health care facility priority system. Sec. 142. Priority of certain projects protected. Sec. 143. Indian health care delivery demonstration projects. Sec. 144. Tribal management of federally owned quarters. Sec. 145. Other funding, equipment, and supplies for facilities. Sec. 146. Indian country modular component facilities demonstration program. Sec. 147. Mobile health stations demonstration program. Subtitle D—Access To Health Services	

		Sec. 151. Treatment of payments under Social Security Act health benefits programs. Sec. 152. Purchasing health care coverage. Sec. 153. Grants to and contracts with the Service, Indian tribes, tribal organizations, and urban Indian organizations to facilitate outreach, enrollment, and coverage of Indians under Social Security Act health benefit programs and other health benefits programs. Sec. 154. Sharing arrangements with Federal agencies. Sec. 155. Eligible Indian veteran services. Sec. 156. Nondiscrimination under Federal health care programs in qualifications for reimbursement for services. Sec. 157. Access to Federal insurance. Sec. 158. General exceptions. Sec. 159. Navajo Nation Medicaid Agency feasibility study. Subtitle E—Health Services For Urban IndianS Sec. 161. Facilities renovation. Sec. 162. Treatment of certain demonstration projects. Sec. 163. Requirement to confer with urban Indian organizations. Sec. 164. Expanded program authority for urban Indian organizations. Sec. 165. Community health representatives. Sec. 166. Use of Federal Government facilities and sources of supply; health information technology. Subtitle F—Organizational Improvements Sec. 171. Establishment of the Indian Health Service as an agency of the Public Health Service. Sec. 172. Office of Direct Service Tribes. Sec. 173. Nevada area office. Subtitle G—Behavioral Health Programs Sec. 181. Behavioral health programs. Subtitle H—Miscellaneous Sec. 191. Confidentiality of medical quality assurance records; qualified immunity for participants. Sec. 192. Limitation on use of funds appropraited to the Indian Health Service. Sec. 193. Arizona, North Dakota, and South Dakota as contract health service delivery areas; eligibility of California Indians. Sec. 194. Methods to increase access to professionals of certain corps. Sec. 195. Health services for ineligible persons. Sec. 196. Annual budget submission. Sec. 197. Prescription drug monitoring. Sec. 198. Tribal health program option for cost sharing. Sec. 199. Disease and injury prevention report.	

		Sec. 200. Other GAO reports. Sec. 201. Traditional health care practices. Sec. 202. Director of HIV/AIDS Prevention and Treatment. TITLE II—AMENDMENTS TO OTHER ACTS AND MISCELLANEOUS PROVISIONS Sec. 201. Elimination of sunset for reimbursement for all Medicare part B services furnished by certain indian hospitals and clinics. Sec. 202. Including costs incurred by aids drug assistance programs and indian health service in providing prescription drugs toward the annual out-of-pocket threshold under part D. Sec. 203. Prohibition of use of Federal funds for abortion. Sec. 204. Reauthorization of Native Hawaiian health care programs.	
S.465 Independent Outside Audit of the Indian Health Service Act of 2017 **Senate Committee on Indian Affairs** **Sponsor: Sen. Mike Rounds (R-SD)** https://www.congress.gov/bill/115th-congress/senate-bill/465/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=19	Introduced: 2/28/2017	To provide for an independent outside audit of the Indian Health Service. (d) Areas Of Study.—Each assessment conducted under subsection (b) shall address each of the following: (1) Current and projected demographics and unique health care needs of the patient population served by the Service. (2) Current and projected health care capabilities and resources of the Service, including hospital care, medical services, and other health care furnished by non-Service facilities under contract with the Service, to provide timely and accessible care to eligible patients. (3) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Service facilities, including whether it is recommended that the Secretary have the authority to furnish such care and services at such facilities through the completion of episodes of care. (4) The appropriate systemwide access standard applicable to hospital care, medical services, and other health care furnished by and through the Service, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation. (5) The workflow process at each medical facility of the Service for scheduling appointments to receive hospital care, medical services, or other health care from the Service. (6) The organization, workflow processes, and tools used by the Service to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.	2 cosponsors

		(7) The staffing level at each medical facility of the Service and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following: (A) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week. (B) The time spent by such health care provider on matters other than the case load of such health care provider. (C) The amount of personnel used for administration compared with direct health care in the Service being comparable to the amount used for administration compared with direct health care in private health care institutions. (D) The allocation of the budget of the Service used for administration compared with the allocation of the budget used for direct health care at Service-operated facilities. (E) Any vacancies in positions of full-time equivalent employees that the Service— (i) does not intend to fill; or (ii) has not filled during the 12-month period beginning on the date on which the position became vacant. (F) The disposition of amounts budgeted for full-time equivalent employees that is not used for those employees because the positions of the employees are vacant, including— (i) whether the amounts are redeployed; and (ii) if the amounts are redeployed, how the redeployment is determined. (G) With respect to the approximately 3,700 Medicaid-reimbursable full-time equivalent employees of the Service— (i) the number of those employees who are certified coders; and (ii) whether that number of employees is necessary. (8) The information technology strategies of the Service with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by the Service, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Service in Service or non-Service facilities.	

		(9) Business processes of the Service, including processes relating to furnishing non-Service health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows: (A) To avoid the payment of penalties to vendors. (B) To increase the collection of amounts owed to the Service for hospital care, medical services, or other health care provided by the Service for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate. (C) To increase the collection of any other amounts owed to the Service with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate. (D) To increase the accuracy and timeliness of Service payments to vendors and providers. (10) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Service, including the following: (A) The prices paid for, standardization of, and use by the Service of, the following: (i) Pharmaceuticals. (ii) Medical and surgical supplies. (iii) Medical devices. (B) The use by the Service of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services. (C) The strategy and systems used by the Service to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to medical facilities of the Service. (11) The process of the Service for carrying out construction and maintenance projects at medical facilities of the Service and the medical facility leasing program of the Service, including— (A) whether the maintenance budget is updated or increased to reflect increases in maintenance costs with the addition of new facilities and whether any increase is sufficient to support the growth of the facilities; and (B) what the process is for facilities that reach the end of their proposed life cycle.	

		(12) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management, including— (A) the reasons for a lack in transparency in the culture of the Service, leading tribal leadership to request increased transparency and more open communication between the Service and the people served by the Service; and (B) whether any checks and balances exist to assess potential fraud or misuse of amounts within the Service. (13) The lack of a funding formula to distribute base funding to the 12 Service areas, including the following: (A) The establishment of the current process of funding being distributed based on historical allocations and not on need such as population growth, number of facilities, etc. (B) How the implementation of self-governance policies has impacted health care delivery. (C) The communication to area office directors on distribution decisionmaking. (D) How the tribal and residual shares are determined for each Indian tribe and the amounts of those shares. (E) The auditing or evaluation process used by the Service to determine whether amounts are distributed and expended appropriately, including— (i) whether periodic or end-of-year records document the actual distributions; and (ii) whether any auditing or evaluation is conducted in accordance with generally accepted accounting principles or other appropriate practices. (14) Whether the Service tracks patients eligible for two or more of either the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), health care received through the Service, or any other Federal health care program (referred to in this section as "dual eligible patients"). If so, how dual eligible patients are managed. (15) The number of procurement contracts entered into and awards made by the Service under section 23 of the Act of June 25, 1910 (commonly known as the "Buy Indian Act") (25 U.S.C. 47), and a comparison of that number, with—	

		(A) the total number of procurement contracts entered into and awards made by the Service during the 5 fiscal years prior to the date of enactment of this Act; and (B) the process used by the Service facilities to ensure compliance with section 23 of the Act of June 25, 1910 (commonly known as the "Buy Indian Act") (25 U.S.C. 47). (16) Any other items the reputable private entity determines should be addressed in the independent assessment of the Service.	
H.R. 235 Indian Health Service Advance Appropriations Act of 2017 **House Budget Committee** **House Natural Resources Committee** **House Energy and Commerce Committee** **Sponsor: Rep. Don Young (R-AK-At Large)** https://www.congress.gov/bill/115th-congress/house-bill/235/text?q=%7B%22search%22%3A%5B%22American+Indian%22%5D%7D&r=16	Introduced: 1/3/2017	To amend the Indian Health Care Improvement Act to authorize advance appropriations for the Indian Health Service by providing 2-fiscal-year budget authority, and for other purposes. **SEC. 2. ADVANCE APPROPRIATIONS FOR CERTAIN INDIAN HEALTH SERVICE ACCOUNTS.** (a) In General.—Section 825 of the Indian Health Care Improvement Act (25 U.S.C. 1680o) is amended— (1) by inserting "(a)" before "There are authorized"; and (2) by adding at the end the following: "(b) For each fiscal year, beginning with the first fiscal year that starts during the year after the year in which this subsection is enacted, discretionary new budget authority provided for the Indian Health Services and Indian Health Facilities accounts of the Indian Health Service shall include advance discretionary new budget authority that first becomes available for the first fiscal year after the budget year. "(c) The Secretary shall include in documents submitted to Congress in support of the President's budget submitted pursuant to section 1105 of title 31, United States Code, for each fiscal year to which subsection (b) applies detailed estimates of the funds necessary for the IndianHealth Services and Indian Health Facilities accounts of the Indian Health Service for the fiscal year following the fiscal year for which the budget is submitted.". (b) Submission Of Budget Request.—Section 1105(a) of title 31, United States Code, is amended by adding at the end the following new paragraph:	

		EXECUTIVE ORDERS & PRESIDENTIAL MEMORANDUMS	
Presidential Executive Order 13781 on a Comprehensive Plan for Reorganizing the Executive Branch https://www.gpo.gov/fdsys/pkg/FR-2017-03-16/pdf/2017-05399.pdf	Issued: 3/13/2017	• OMB, within 180 days after public comment, is to propose a plan to reorganize government functions and eliminate unnecessary agencies and agency programs • Each agency must submit a plan to the OMB director to reorganize the agency, if appropriate, in order to improve the efficiency, effectiveness, and accountability of that agency • OMB will publish a notice in the federal register inviting public comment to suggest improvements in the reorganization and functioning of the executive branch. • In developing OMB's plan, things that should be taken into consideration include: (i) whether some or all of the functions of an agency, a component, or a program are appropriate for the Federal Government or would be better left to State or local governments or to the private sector through free enterprise; (ii) whether some or all of the functions of an agency, a component, or a program are redundant, including with those of another agency, component, or program; (iii) whether certain administrative capabilities necessary for operating an agency, a component, or a program are redundant with those of another agency, component, or program; (iv) whether the costs of continuing to operate an agency, a component, or a program are justified by the public benefits it provides; and (v) the costs of shutting down or merging agencies, components, or programs, including the costs of addressing the equities of affected agency staff. **Recommendations:** Obviously our first concern is keeping IHS. Once the comment period happens, it's important to get notice out to Tribes quickly and get template comments out there asking for preservation of IHS. However we need to be careful about any other suggestions we might make to make the agency more accountable.	IHS will be holding All Tribes Calls prior to the final reform plan submission. https://www.whitehouse.gov/reorganizing-the-executive-branch Importance to head agencies with office of tribal affairs OMB Memo: provides agencies guidance to begin immediate actions to reduce the workforce and cost sayings (President's Budget); **submit an agency reform plan to OMB in September 2017.**

		The other thing to take into consideration is that IHS already has a plan to reorganize the agency to do just what this EO is proposing to do that was started under Mary Smith. It might be prudent to ask IHS to share that plan with Tribes so that they can support it in their recommendations and comments.	
COMMENTS SUBMITTED			
CDC Diabetes Prevention Recognition Program (DPRP) Notice Docket No. CDC-2017-0053	Published: 7/14/2017 **Submitted: 9/13/2017**	NPAIHB applauds the effort of CDC to recognize organizations that deliver preventative services to individuals diagnosed with pre-diabetes through the CDC DPRP. CDC must recognize that tribes do not have the infrastructure and capability to implement and monitor the CDC DPP without additional funding to support the operational and logistical components needed to participate. This program is labor intensive and requires a number of individuals to be key leaders as well as educators and alternates that are needed to increase support and beneficiary participation. NPAIHB and our member tribes recommend that CDC create another recognition path to grandfather SDPI programs using the SDPI measurement and reporting criteria through a CDC pilot project. NPAIHB and our member tribes believe that the CDC Diabetes Prevention Program (DPP) participation requirements are significant barriers for tribal health programs to pursue recognition, especially small community health centers in Indian Country. The program, in its current form, deters tribal health program participation and will not benefit tribal health programs. NPAIHB recommends that CDC work with IHS and tribes through meaningful tribal consultation to incorporate SDPI and tribal participation in the DPP. Additionally, NPAIHB would like to recommend for CDC to conduct an outreach and education initiative for SDPI and tribal health care programs to become CDC-recognized DPP organizations. NPAIHB is concerned about the 12-month data submission to CDC	

		because it is not applicable in our communities to collect the data when there is no support or funding within an already under-served health care community. The CDC recognition process can take up to two years to accomplish full CDC-recognition status. A majority of tribal health care programs are unaware of the process, the criteria, and the period of time it takes programs to become CDC-recognized. NPAIHB requests that I/T/U health programs not be required to coordinate with an additional federal agency to IHS regarding recognition. It is a burden for tribal health programs to report and participate in three different diabetes prevention recognition programs administered by three federal agencies under the U.S. Department of Health and Human Services (HHS). We request that CDC work with the SDPI programs and recipients to ensure there is alignment, consistency, and coordination of these programs to receive recognition and reimbursement for diabetes prevention services. NPAIHB recommends recognition of other health outcome measures for performance payment because weight loss does not provide an incentive, the goal should be to become a healthier Medicare beneficiary to prevent Type II diabetes. There are various successful evidence-based methods that can be utilized in addition to attendance as performance measures such as reductions in blood sugar levels, lower BMI levels, and increased intake of healthy foods and physical activity. NPAIHB recommends the utilization of measures that have been successful variables in the SDPI such as reductions in blood sugar levels, reduced hypertension risk, lower BMI levels, increased intake of healthy foods, increased rate of physical activity, or risk reduction factors should be used instead of weight loss. We also recommend that CDC include a mental health measurement as part of integrated care because behavioral health plays a significant role in changing lifestyle behaviors as well as achieving weight loss, especially in Indian Country where patients may struggle with historical trauma.	

		NPAIHB appreciates the opportunity to submit comments on the CDC DPRP. We note, however, that the public notice and comment period is not a substitute for Tribal consultation pursuant to the CDC Tribal Consultation Policy and Executive Order 13175.	
CMS Medicare Diabetes Prevention Program (MDPP) Proposed Rule CMS-1676-P	Published 7/21/2017 **Submitted: 9/11/2017**	NPAIHB and CRIHB believe that a 1-year core maintenance session is not a realistic time period to see lifestyle behavior changes and weight loss. NPAIHB and CRIHB applaud the effort of CMS to expand services delivered by community-based organizations to Medicare beneficiaries diagnosed with pre-diabetes through the MDPP. However, the structure of the MDPP is problematic with respect to I/T/Us participation. NPAIHB and CRIHB are pleased that CMS will not prevent beneficiaries who develop diabetes from receiving the MDPP services. However, NPAIHB, CRIHB, and our tribal members believe that the program should not be limited to individuals with pre-diabetes. Medicare beneficiaries who have already been diagnosed with diabetes need assistance and support as well. We recommend that Medicare beneficiaries with type II diabetes be included as eligible beneficiaries. NPAIHB and CRIHB recommend that CMS collaborate with SDPI and recipients to ensure there is alignment, collaboration, and consistency with program eligibility. NPAIHB and CRIHB and our member tribes are adamantly against the 5% weight loss goal. The 5% weight loss program participation requirement is a culturally insensitive measurement for AI/ANs. Weight loss alone does not adequately reflect the overall progress a participant is making toward lasting lifestyle changes and the prevention of diabetes. We recommend separate categories for weight loss goals for men and women. Along with the sedentary lifestyle and metabolism barriers, Native women struggle with weight loss more than Native men because of hormonal body changes and gradual lean muscle loss that come with age. We recommend that CMS also take into consideration medical conditions (ex. Thyroid cancer) of Medicare beneficiaries that	 Joint NPAIHB CRIHB Comment on MDPP

		could further limit the possibility to meet the 5% weight loss goal. These are factors that can put further restrictions on the types of Medicare beneficiary participants. NPAIHB and CRIHB would like to reiterate our recommendation that Tribal Health Programs be granted the flexibility to determine their own diabetes prevention measures of success. NPAIHB and CRIHB recommend revalidation of supplier enrollment every five years. NPAIHB and CRIHB would like to restate that the requirement for SDPI Diabetes Prevention (SDPI DP programs be recognized by the Centers for Disease Control and Prevention (CDC) to provide diabetes prevention (DPP) services in order to be eligible to apply for enrollment as a Medicare supplier is an unnecessary requirement. NPAIHB, CRIHB, and our member tribes believe that the MDPP participation requirements are significant barriers for Tribal Health Programs to pursue accreditation in the MDPP, especially small community health centers in Indian Country. The program, in its current form, deters tribal health program participation and will not benefit Tribal Health Programs. NPAIHB and CRIHB propose the creation of another path to grandfather SDPI program recognition using the SDPI measurement and reporting criteria through a CDC pilot project or CMS pilot project. NPAIHB and CRIHB recommend that CMS work with IHS and tribes through meaningful tribal consultation to incorporate SDPI and tribal participation in the MDPP. Additionally, NPAIHB and CRIHB would like to restate our recommendation for CMS and CDC to conduct an outreach and education initiative for SDPI and Tribal health care programs to become CDC-recognized Diabetes Prevention Program organizations in order to enroll in the MDPP beginning on April 1, 2018. NPAIHB and CRIHB support the proposal for MDPP lifestyle coaches to obtain an NPI number. The majority of SDPI programs are already designated as Medicare providers and will only have to obtain an NPI number for their lifestyle coaches. NPAIHB and CRIHB request that more trainings be available to become lifestyle coaches, especially in remote areas.	

		NPAIHB and CRIHB are concerned about the 12-month data submission to CDC because it is not applicable in our communities to collect the data when there is no support or funding within an already under-served health care community. NPAIHB and CRIHB recommend that CMS conduct a pilot program for currently operating SDPI Diabetes Prevention programs to be certified as grandfathered in to provide services and receive reimbursement through the MDPP. NPAIHB and CRIHB would like to reiterate that the request for I/T/U programs to not be required to coordinate with an additional federal agency, the CDC, regarding recognition. It is a burden for Tribal Health Programs to report and participate in three different federal agencies under the U.S. Department of Health and Human Services (HHS). Furthermore, while this proposed rule affects only the Medicare program, NPAIHB and CRIHB recommend implementation of a similar program for Medicaid. In the implementation of a Medicaid Diabetes Prevention Program model, NPAIHB and CRIHB would urge that a mechanism be developed to allow Federally Qualified Health Centers (FQHC) and IHS/Memorandum of Agreement (MOA) clinic providers to receive additional reimbursement outside of their all-inclusive rate when providing these preventive services. . NPAIHB and CRIHB applaud CMS efforts to include a performance category without the 5% weight loss. However, the total performance payment per beneficiary without the 5% weight loss is $125 compared to $810 for a beneficiary who meets the 5% weight loss goal. NPAIHB and CRIHB believe that the reimbursement for beneficiaries who do not meet the 5% weight loss is unacceptable and is not cost beneficial for Tribal Health Programs to participate. NPAIHB and CRIHB recommend increased performance payments per beneficiary who do not meet the 5% weight loss goal. We also recommend recognition of other health outcome measures for performance payment because weight loss does not provide an incentive, the goal should be to become a healthier Medicare beneficiary to prevent type II diabetes.	

		NPAIHB and CRIHB reiterate our recommendation to utilize measures that have been successful variables in the SDPI such as reductions in blood sugar levels, reduced hypertension risk, lower BMI levels, increased intake of healthy foods, increased rate of physical activity, or risk reduction factors should be used instead of weight loss. We also recommend that CMS include a mental health measurement as part of integrated care because behavioral health plays a significant role in changing lifestyle behaviors as well as achieving weight loss, especially in Indian Country where patients struggle with historical trauma in the community. NPAIHB and CRIHB applaud CMS efforts to include MDPP virtual make-up services through virtual service capabilities for reimbursement for Tribal health care programs with broadband capabilities. Tribal health programs that serve patients in rural geographic regions could increase patient access to the Medicare preventive diabetes services if virtual access is expanded. NPAIHB and CRIHB request that CMS provide related funding opportunities to address rural internet access and information technology infrastructure, which are often barriers for rural tribal health care organizations interested in providing virtual services. NPAIHB and CRIHB believe that the restrictions on incentives for participation should not be as limiting because incentives such as cooking classes and gym memberships, which may be more expensive than the monetary value outlined can be key incentives to adjust to a new lifestyle. NPAIHB and CRIHB appreciate the opportunity to submit comments on the Medicare Reimbursement Expansion of the Diabetes Prevention Program. We note, however, that the public notice and comment period is not a substitute for Tribal consultation pursuant to the CMS Tribal Consultation Policy and Executive Order 13175. NPAIHB and CRIHB urge CMS to engage in Tribal consultation with the	

		Indian Health Care system, including I/T/Us, prior to publication of a final rule in addition to consideration of these comments.	
IHS RPMS Electronic Health Record (EHR) DTLL	Published: 06/27/2017 **Submitted: 8/30/2017** **Due Date: Extended to 10/31/2017**	NPAIHB fully supports the modernization and improvement of the RPMS EHR system. NPAIHB requests that IHS conduct Area consultations prior to the final decision of whether to modernize the current RPMS EHR or move to a new EHR system. NPAIHB recommends that the RPMS improvements or the new EHR system must revolve around the benefits to patient care by improving the involvement and utilization of providers in the health IT system. NPAIHB recommends that IHS participate in the forefront of the policy development process for other agencies in the creation of reporting requirements for reimbursement purposes. NPAIHB recommends that there needs to be a boot camp style training in a classroom environment and then one on one support when you run into a problem back at home using a screen share. NPAIHB requests additional training and technical support, especially for smaller tribal health clinics. NPAIHB recommends that IHS utilize a more user-friendly format to identify to providers if the software system needs to be updated. NPAIHB recommends that the RPMS system include a preventative care section for providers to report on. It is a barrier for providers to enter in patient group education and documentation for preventative care. NPAIHB recommends that IHS make operability more of a focus in the modernization of the RPMS or a new EHR system, so that the system is more streamlined and aligned with other EHR systems. NPAIHB recommends that the technical support be more timely available for responsiveness to software issues. The billing package for RPMS is a barrier because it is not robust enough	 NPAIHB RPMS Comment.docx

		to handle sites that see non-tribal members. This is a significant issue because tribal providers are the ones providing health care services in these rural areas, therefore this barrier impacts the tribal health system. NPAIHB recommends that the RPMS EHR system should allow providers to be able to see the brand name and generic name of medications. Additionally, there is a need for better maneuvering of the medications that providers are able to view and interact with.	